

**NATIONAL CAPITAL AREA  
CHCS AD HOC REQUEST FORM  
Approved by TRICARE REGION 1 MIMC 1AUG02**

To request an AD HOC report, please fill in the information below. Print and fax to 301-295-6669. You may also save completed form as a file and include as enclosure in email to [Ad Hoc Functional Working Group AHFWG Chair](#) Incomplete forms will be rejected!

Requestors Name (Last): \_\_\_\_\_ (First): \_\_\_\_\_

MTF/Dept/Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Pager: \_\_\_\_\_

Purpose of Report: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Report Frequency: One-time\_\_\_ Ongoing\_\_\_ Weekly\_\_\_ Monthly\_\_\_ Qtrly\_\_\_ Annually\_\_\_  
Report Due Date: \_\_\_\_\_

**\*\*NOTE:** Upon review and approval by the NCA Ad Hoc Committee, report requests will be placed in priority order according to CHCS Project Office mission[s]. Expect at least a 2 week waiting period\*\*

Information Required: (\*\*Include DATE RANGE\*\*) (State sort criteria, i.e. Alpha, numeric, date order, register number order, etc)

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Output Format: **\*\*NOTE:** All AD HOC reports produce TEXT output. Use this field to describe (specifically) how you want the report data laid out on the page. (i.e. patient name, appointment date, FMP/SSN, etc.)

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NCA Ad Hoc Committee

Approved:

Rejected:

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